DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

DHSS STAFF

Inactivated INFLUENZA Vaccine (IIV) "Flu Shot" Administration Record Consent – Declination Form

Name (Last, First, MI):			**Gender:** ☐ M ☐ F ☐ Trans ☐ Other
Street address:			**Phone:**
City:		**State:**	**ZIP Code:**
Date of Birth:	**Age:**	**Hispanic Ethnicity:** ☐Yes ☐No	**Haitian?** ☐Yes ☐No
Race (Check all that apply): ☐ White ☐Black ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐American Indian/Alaska Native			
Insurance: ☐ None ☐Medicare ☐ Medicaid ☐CHIP/DHCP* ☐ Private_____			

Medical Screening	Yes	No	Clinician's Note
Are you sick today (with a moderate to severe illness)?	☐	☐	
Have you ever had a serious allergic reaction to: • Influenza vaccine? • Eggs, egg proteins or products? • Natural rubber latex; or other substances? _____	☐	☐	
Have you ever had Guillain-Barré syndrome?	☐	☐	
What is your approximate weight?	_____lbs		

Complete the next section and sign **after** you have talked with the clinician

YES, I WANT TO PROTECT MYSELF & AVOID SPREADING THE FLU TO MY FAMILY, PATIENTS & CO-WORKERS.
My signature (below) means that I have been given a copy of the Inactivated Influenza Vaccine ("Flu Shot") Vaccine Information Statement (VIS) and have read, or have had explained to me, information about Influenza and the Inactivated Influenza Vaccine ("Flu Shot"). I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits as set forth in the VIS I was given and I ask that the vaccine, as marked, be given.

Signature _____ Signer's Name _____
Employee Date_____ Print Clearly

NO, I HAVE ALREADY BEEN VACCINATED!
I have already received the influenza vaccine this flu season.

Date Vaccinated:_____ Provider Name/Office Location:_____

Signature _____ Signer's Name _____
Employee Date_____ Print Clearly

DECLINATION: *I have decided to decline influenza vaccination at this time for the reason(s) listed below:*
Reasons: _____
I understand that I am eligible for vaccination. I have been given a copy of the Inactivated Influenza ("Flu Shot") Vaccine Information Statement (VIS) and have read, or have had explained to me, information about Influenza and the inactivated influenza vaccine ("Flu Shot"). I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits as set forth in the VIS I was given. I understand I will be required, per agency policy, to wear a mask while interacting with patients or clients wherever they typically may be present. The mandatory masking requirement will extend annually from November 1 through April 30 and also during any declared influenza outbreak.
Signature _____ Signer's Name _____
Employee Date_____ Print Clearly

Do not write below this line. For Clinician use only.

NHS ___ SHS ___ Clinic Location: _____

Preparation/Route: (Check one)	**Dose:**	**Site:**	**Vaccination Date:**
☐ **Fluarix/Quad Inj. P-Free/IM** ☐ **FluLaval/Quad Inj. P-Free/IM** ☐ **Fluzone/Quad Inj. P-Free/IM**	**0.5ml ___**	**RA ___ RT ___ LA ___ LT ___**	_____

VIS Date:	**Date VIS Given:**	**Manufacturer (circle one):**	**Lot #:**	**Expiration Date:**
8/18/19		Sanofi GSK		

Clinician's Name (Print Clearly)	**Clinician's Signature:**	**License Title:**